State of West Virginia • Public Employees Insurance Agency
Change-In-Status Form

Change in Status

Complete this form to change the status of your coverage. Complete all sections as appropriate except the Employer Information on page 2 and return the form to your benefit coordinator.

Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number

Street Address Check if New Address c	County of Residence	Home Phone ( )

City	State	Zip	Job Title	Work Phone ( )

Do you participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES ☐ NO ☐

CHANGE TYPE Please indicate the status change you are making:

001 ☐ Name Change: Policyholder c Dependent c (Last)_____ (First)_____ (MI)_____

002 ☐ Transfer employee's premium billing from employer account # _____ to account # _____ within the same agency

003 ☐ Add Dependents to: (Mark your choice) c Health c Dependent Optional Life Insurance (check one) c Plan 1 c Plan 2 c Plan 3 c Plan 4
(Complete dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.)

004 ☐ Remove Dependents from: (Mark your choice and complete dependent information below) c Health c Dependent Optional Life Insurance

005 ☐ Change in health coverage: From: (Plan Name)_____ To: (Plan Name) _____

006 ☐ Add Health Coverage: c PEIA PPB Plan A c PEIA PPB Plan B c PEIA PPB Plan C c PEIA PPB Plan D
c Health Plan HMO Plan A c Health Plan HMO Plan B

007 ☐ Drop Health Coverage. Keep life insurance ONLY. This terminates health coverage for policyholder and all dependents.

008 ☐ Tobacco Status Change.

009 ☐ Advance Directive/Living Will Affidavit Change.

Dependent Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)	Sex (Circle One)	Birth Date (mm/dd/yyyy)	Social Security Number
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		

Status Change Reason. Policyholder must provide documentation for every type of status change. See attached memo for details.

1	☐	Marriage	5	☐	Death of spouse or dependent	9	☐ Change from full-time to part-time employment or vice versa for employee, spouse, or dependent
2	☐	Divorce	6	☐	Beginning or end of spouse's or dependent's employment	10	☐ Open Enrollment
3	☐	Birth of Child	7	☐	Significant change in health coverage due to spouse's or dependent's employment	11	☐ Other (please specify): _____
4	☐	Adoption	8	☐	Unpaid leave of absence by employee, spouse, or dependent		

I certify that on _____/_____/_____(date of event) I incurred the status change marked above, and I, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the event. I further understand that I am required to provide documentation of this event to the WV Public Employees Insurance Agency.

This form is continued on page 2. You must complete and return both pages of the form for it to be valid. Please continue.

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Page 2

Policyholder's Last Name: _____ Last four digits of SSN: _____

COBRA

Under Federal COBRA law, PEIA must offer continued coverage to qualified policyholders or dependents under certain circumstances. If you qualify, you will be sent notification with the necessary applications by HealthSmart Benefit Solutions, who administers COBRA for the PEIA. You will have a limited amount of time to elect continuation of coverage. If dependent's address is different than the policyholder's address, please provide the dependent's address here:

Dependent Name: _____

Street Address: _____

City, State, Zip _____

Premium Discount Affidavits

Tobacco Affidavit: Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your coverage uses tobacco, you will receive a premium discount on your health coverage and/or optional life insurance. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: c Policyholder c Dependent (spouse and/or children) c No Tobacco Users within the last six (6) months

Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form in the Acceptance box below.

c By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.

Acceptance

I hereby accept the changes to my group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the changes I have made may affect my contributions. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, of all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.

Employee's Signature: Date:

Employer Information -- TO BE COMPLETED BY AGENCY BENEFIT COORDINATOR

Account Number

Agency Name (optional): _____

Effective Date of Status Change

		/			/				
		/			/				

Index Code

I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: Date:

Please submit only the original to PEIA

Status Change Event	Documentation Required
Divorce	Provide a copy of the divorce decree showing the date the divorce is final
Marriage	Copy of valid marriage license or certificate
Birth of Child	Copy of child's birth certificate
Adoption	Copy of adoption papers
Adding coverage for a dependent	Copy of child's birth certificate
Open enrollment under spouse's or dependent's benefit plan	A copy of printed material showing open enrollment dates and the employer's name
Death of spouse or dependent	A copy of the death certificate
Beginning of spouse's or dependent's employment	A letter from the employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered
End of spouse's or dependent's employment	A letter from the employer stating the termination or retirement date, what coverage was lost, and what dependents were covered
Significant change in health coverage due to spouse's or dependent's employment	A letter from the insurance carrier indicating the change in insurance coverage, the effective date of the change, and the dependents covered
Unpaid leave of absence by policyholder, spouse, or dependent	A letter from your, your spouse's, or your dependent's personnel office stating the date that you, your spouse, or your dependent went on unpaid leave or returned from unpaid leave
Change from full-time to part-time employment or vice versa for policyholder, spouse, or dependent	A letter from your, your spouse's, or your dependent's employer stating the previous hours worked and the new hours worked as well as the effective date of the change